ARIZONA DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES

FINANCIAL APPLICATION

For CRS Use Only
CRS ID Number/ Medical Record Number/ Category

Applicant (Child) Name (Last, First, Mi)	Sex: ☐ Male ☐ Female	Birth Date
Race	Marital Status	Applicant's Social Security Number
Ward of Court ☐ Yes ☐ No	Place of Birth	Home/Message Phone # ☐ Home ☐ Message Phone
Residential Address (Street, City, State, Zip Code)		County
Mailing Address (P.O. Box,Street, City, State, Zip Code) (If different than above)		

Father's Name (Last, First, MI)	Father's Social Security Number	Date of Birth
Father's Employer	Father's Work Phone Number	
Father's Work Address		

Mother's Name (Last, First, MI)	Mother's Maiden Name	Mother's Social Security Number	Date of Birth
Mother's Employer		Mother's Work Phone Number	
Mother's Work Address			
Name of Guardian		Work Phone Number	

Other Household Members (Names and Ages)			
1.	2.	3.	4.
5.	6.	7.	8.

HEALTH INSURANCE

Is the child covered by Health Insurance (HMO, PPO, AHCCCS, KidsCare, Indemnity)? ☐ Yes ☐ No
If possible, please include a copy of insurance card(s)

Insurance Policyholder's Name	Date of Birth	Insurance Policyholder's Name	Date of Birth
Primary Insurance Company		**Secondary** Insurance Company	
Billing Address		Billing Address	
	Phone Number		Phone Number
Policy/Plan Number	ID Number / Group Name/Number	Policy/Plan Number	ID Number / Group Name Number
Eligibility Code	End Date	Eligibility Code	End Date
AHCCCS I.D. / AHCCCS Plan Number / For CRS Use- Key Code		AHCCCS I.D. / AHCCCS Plan Number / For CRS Use-Key Code	
Coverage Type/s: ☐ Medical ☐ Dental ☐Vision ☐ Pharmacy		Coverage Type/s: ☐ Medical ☐ Dental ☐Vision ☐ Pharmacy	
Does the child receive services from:		Does the patient receive services from:	
☐ Adoption Subsidy	☐ CMDP	☐ DDD	☐ SSI
☐ Other Agency (Please be specific)			
Comments:			

Signature of Financially Responsible Person _____ **Date**_____

Household Gross Income:

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